DEPARTMENT OF THE NAVY
NAVAL INSPECTOR GENERAL
1254 9TH STREET SE
WASHINGTON NAVY YARD DC 20374-5006

IN REPLY REFER TO:

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15 May 14

From: Naval Inspector General
To: Distribution

Subj: COMMAND ASSESSMENT OF NAVAL MEDICAL CENTER PORTSMOUTH

Ref: (a) SECNAVINST 5430.57G
(b) OGC MEMORANDUM FOR NAVAL IG of 10 Mar 14
(c) VCNO letter Ser N09/14U100513 of 7 FEB 2014

1. The Naval Inspector General (NAVINSGEN) conducts inspections and surveys as directed by reference (a), making appropriate evaluations and recommendations to the Secretary of the Navy and the Chief of Naval Operations concerning operating forces afloat and ashore, Department of the Navy (DON) components and functions, and Navy programs which impact readiness or quality of life of military and civilian Naval personnel.

2. In response to references (b) and (c), NAVINSGEN conducted a Command Assessment of Naval Medical Center Portsmouth (NMCP) from 21 to 25 April 2014. The NAVINSGEN assessment team was augmented by a Sexual Assault Prevention and Response (SAPR) expert from OPNAV N17 and the Navy Bureau of Medicine and Surgery (BUMED) Inspector General (MEDIG). This report documents our findings.

3. This report has three parts. Part 1 is the Executive Summary. Part 2 forwards our overall observations and findings and documents discrepancies noted during the assessment. Part 3 contains a summary of survey and focus group data, as well as a complete listing of survey frequency data.

4. During our visit we assessed overall command climate, including command member attitudes and practices concerning fraternization and professional conduct, and evaluated the command's SAPR and Physical Readiness Programs. In addition, we reviewed the Limited Duty (LIMDU) program management, command legal records, manpower/manning, General Military Training (GMT), Personnel Qualification Standards (PQS), and selected Enlisted Sailor programs under the purview of senior enlisted leadership. Additionally, we conducted surveys, focus group discussions and individual interviews to assess command climate.

5. NMCP is a large, complex organization with a workforce that is committed to providing work-class health care in the setting of some significant and challenging demands. The command climate varies across work centers and between different levels in the organizational hierarchy. As with any large command, there are some very strong elements, and there are opportunities for improvement. One of the biggest challenges the command faces is improving communications from senior leadership to the chain of command, and clearing perceptions that the leadership team is not receptive to feedback from junior personnel. In addition, the staff feels the stress associated with a significant workload, and also commented on perceived tension between initiatives to "recapture" care referred to the Tricare network, hospital capacity and perceptions of the associated impact on patient quality care and safety.

6. We assess that the command is proactive in investigating and addressing issues involving fraternization, and we found no evidence of a culture of fraternization or alcohol abuse. Going forward the command must continue an active program of training and mentoring their personnel to stay ahead of problems.

7. In the course of our assessment, we identified several discrepancies in the SAPR program and perceived barriers to reporting that prevent effective program implementation. These discrepancies are readily correctable and the command team was receptive to NAVINSGEN feedback.

8. The Physical Readiness and LIMDU programs are presently compliant, and NAVINSGEN provided some minor recommendations for improvements.

9. Corrective actions. Part 2 of this report documents nine deficiencies in the SAPR program that require corrective action. All documented deficiencies are within the capacity of NMCP to correct. Correction of each deficiency, and a description of action(s) taken, should be reported via letter by NMCP to Chief, Bureau of Medicine and Surgery Inspector General (MEDIG) no later than 15 July 2014. Deficiencies not corrected by this date or requiring longer-term solutions should be updated quarterly until completed. MEDIG shall report completion status to NAVINSGEN starting in July 2014, and every quarter thereafter, until completed. Additionally, NAVINSGEN provided Commander, NMCP with five separate recommendations, for their

consideration, relating to SAPR and LIMDU personnel management. Follow up reporting on these recommendations is not required.

10. MEDIG will conduct a follow-up visit within 90 days of this report and provide their findings to NAVINSGEN.

11. My point of contact is b6 b7c, b6 b7c, Inspections Division. b6 b7c can be reached at (202) 433-b6 b7c, DSN 288-b6 b7c, or via e-mail at b6 b7c@navy.mil.

J. F. CALDWELL, JR.

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NAVAL INSPECTOR GENERAL
COMMAND ASSESSMENT OF
NAVAL MEDICAL CENTER PORTSMOUTH
21 TO 25 APR 2014

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PART 1

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

1. The Naval Inspector General (NAVINSGEN) conducted a command assessment of Naval Medical Center Portsmouth (NMCP) in Portsmouth, Virginia from 21 – 25 April 2014. The NAVINSGEN assessment team was augmented by a Sexual Assault Prevention and Response (SAPR) expert from OPNAV N17 and the Navy Bureau of Medicine and Surgery Inspector General (MEDIG).

2. NMCP is a large, complex organization with a workforce that is very committed to its mission of providing world-class health care. The command has a total staff of 6,736 (including officers, enlisted, General Schedule (GS) employees and contractors) with an annual operating budget of $499M and is comprised of 18 Directorates, 187 Departments, and 9 Branch Health Clinics ranging from Yorktown, Virginia to southern Chesapeake, Virginia.

3. In the course of our assessment we implemented an online survey, conducted focus group discussions and interviews, and evaluated the following programs and areas:

a. Sexual Assault Prevention and Response (SAPR)
b. Command Physical Readiness
c. Command legal records
d. Navy Medicine East Inspector General (IG) records pertaining to NMCP
e. General Military Training (GMT)
f. Personnel Qualification Standards (PQS)
g. Enlisted sailor programs including the command sponsorship, command indoctrination, and career development programs.
h. Manpower and manning
i. Management of Limited Duty Personnel at NMCP.

4. Overall assessment.

a. Command Climate. Overall command climate ranges from fair to very good depending on the Department. As with any large command of this size, there are Departments with very healthy climates and others that face challenges and have room for improvement.

(1) Our survey data and direct observations revealed an NMCP staff that is very dedicated to their jobs and quality patient care. We also got a strong sense of a workforce that is clearly passionate about what they do.

(2) Contractors and Department of Navy civilians comprise 50% of the Medical Center staff. A number of civilian personnel felt that they were less valued than military personnel assigned to the command.

(3) Command climate is not homogeneous across NMCP: an individual's perception is a function of their assigned Directorate and relative seniority. Personnel assigned to the Surgical Services Directorate and mid-level leaders expressed the highest degree of dissatisfaction in focus group discussions. Interestingly, the Surgical Directorate is heavily

tasked and in general, feels the brunt of the significant demand for NMCP services. Mid-level leaders voiced concerns about internal communications and wanting their voice to be heard.

(4) A recurring theme from surveys and focus group sessions regarded the effectiveness of communications both up and down the chain of command. Communications at such a large command are frequently a challenge, but we think this is the most important issue facing NMCP leadership. To be successful, leaders must proactively push information downward and must be willing to listen to feedback. There is a sense by a number of personnel at the command, most notably mid-level military and civilian leaders, that feedback up the chain of command is not valued, requested, or considered.

(5) We found no indication of an abusive environment where people are ill-treated, verbally abused or otherwise treated in a disrespectful manner. We do note that some senior leaders are perceived by the Medical Center staff as overly direct, overbearing, and unwilling to listen to recommendations from junior personnel. From the survey data, focus group discussions, and interviews, we got a sense that there is fear of speaking up (not uniformly across the staff, but existent among a number of individuals).

(6) The good news is that the leadership team, including the Command Executive Board (CEB), which serves as a Board of Directors, is aware of their communication problem. Upcoming leadership restructuring and some turnovers present opportunities to tackle this challenge with renewed emphasis.

b. Sexual Assault Prevention and Response (SAPR) program. The Command is committed to ensuring an environment free of sexual assault (SA); however, the program is not compliant with OPNAVINST 1752.1B.

(1) Our pre-arrival survey data shows that over 88% of personnel at NMCP do not question the integrity of the SAPR program. However, Victim Advocate (VA) focus group participants identified potential barriers to SA reporting at the command stemming from a perceived lack of confidentiality in the reporting process as a major concern. We were not able to quantify the scope of this perception at the command; however, we identified two possible causes for this perception:

(a) The command has too many people involved in the SA reporting chain between the victim and the Commander. Sexual Assault victim reports are relayed through multiple levels in the chain of command, potentially compromising confidentiality.

(b) In the Medical Community, anyone with access to medical records could view a victim's record; medical personnel in our focus groups expressed concern about privacy among their peers.

(2) A number of personnel with key roles in the SAPR program have not been formally trained or appointed by the Commander.

(3) The command SAPR instruction is inaccurate and does not fully comply with governing DoD, SECNAV, and OPNAV SAPR instructions.

c. Command Physical Readiness Program (PRP). The PRP at NMCP is in compliance with OPNAVINST 6110.1J. The program was not in compliance up through June 2013, but is now strongly administered. An NMCP self-assessment of the program in July 2013 identified program shortfalls which prompted a series of personnel and process changes to bring the program back into compliance. Of note, Medical Officers who have outstanding service obligations but do not pass the PFA are not consistently processed out of the Navy by Navy Personnel Command (NAVPERSCOM PERS 8) when they exceed three PFA failures within a four year period. By BUMED and NAVPERS policy, some Medical Officers are retained either because of their outstanding service obligation or medical specialty. There are documented instances at NMCP where Medical Officers have been processed for administrative separation for PFA failures, but are ultimately retained by NAVPERS. This creates the perception that some Medical Officers at the command are not being held to the same standards as other members of the command.

d. Fraternization and Culture of Alcohol Abuse. We found no direct evidence of fraternization or a culture of alcohol abuse other than those few cases previously investigated by the command. We assess that the command is proactive in investigating and addressing issues involving fraternization. Of note, there is an at-risk population that includes interns and resident doctors who are relatively new to the team and are under pressure to learn quickly. The command must continue strong training and mentoring to prevent future occurrences.

e. Workload is increasing as the Medical Center attempts to "recapture" a portion of care that is currently referred to the Tricare network. This presents some significant challenges and creates tension between productivity capacities, quality of life and perception of quality care. There are some barriers to reaching recapture goals, such as operating room capacity and some administrative inefficiencies associated with the time required to document care and treatment in the current medical record system. Command leaders understand the current workload but in our view will have to do these things: (1) ensure clear communication of recapture intent and purpose; (2) carefully monitor the demands on the staff as recapture efforts expand; and (3) ensure the NMCP staff understands the processes and methods in place to monitor quality patient care/safety and the means by which NMCP staff can elevate concerns or perceptions about these areas. Some Departments may not be able to recapture due to the nature of their work, limiting factors that they cannot control, and the fact that they are already at a very high level of productivity.

f. All of the Medical Center's senior leadership (Directors, Command Master Chief, Deputy Commander, and Commander) occupies administrative spaces in Building One, physically separate from the rest of the Medical Center which operates out of a number of other buildings on the campus. These leaders do make their rounds and see patients in the Medical Center; however, the physical dislocation of these leaders is a potential barrier to effective communications and interactions. Additionally, the Commander is multi-hatted as Navy Medicine East; Director, Multi Service Market; and Director, Medical Service Corps, which collectively requires significant time away from the Medical Center.

g. The Medical Center currently manages nearly 500 assigned Limited Duty (LIMDU) personnel. This workforce provides additional capacity for a multitude of NMCP tasks, but also presents challenges and potential risks. There are many dimensions to these challenges including the required overhead to manage this large number of personnel and a growing percentage of the LIMDU population with mental health issues. This growing population is a by-product of changes to Department of Defense policy that shifts care of mental health patients to a LIMDU/ Physical Evaluation Board process vice (previously) an administrative separation process. When considering the full mental health demand on NMCP, there can be delays in appointments and therefore longer timeframes that a patient spends in a LIMDU status. NMCP is well aware of the full range of issues involved in managing a large LIMDU population, and has assigned appropriate personnel to manage the program. Going forward, NMCP needs to codify their process and the leadership team needs to remain fully engaged to ensure program success and manage risks.

PART 2

OBSERVATIONS AND FINDINGS

AREAS/PROGRAMS ASSESSED

1. The Naval Inspector General (NAVINSGEN) conducted an assessment of Naval Medical Center Portsmouth (NMCP) in Portsmouth, Virginia from 21 – 25 April 2013. The NAVINSGEN assessment team was augmented by a Sexual Assault Prevention and Response (SAPR) expert from OPNAV N17 and the Navy Bureau of Medicine and Surgery (BUMED) Inspector General (MEDIG).

2. In the course of our assessment NAVINSGEN:

a. Engaged NMCP personnel through the use of an anonymous survey that asked questions relating to command climate, fraternization, use of alcohol, the SAPR program, and the Command Physical Readiness program. Based on the reported NMCP population, the sample was representative and achieved a 2.2% margin of error with a 99% confidence level.

b. Conducted 19 focus group discussions with personnel at NMCP and Boone Branch Health Clinic on the Joint Expeditionary Base, Little Creek-Fort Story to gain additional information on the topics listed above.

c. Conducted personal interviews with military, DON civilian employees, and contractor personnel across all leadership levels at NMCP and Boone Clinic.

d. Evaluated the Command SAPR and Physical Readiness programs.

e. Reviewed Command legal records (2012 to date), including Command Investigations, Preliminary Inquiries, Administrative Separations, and the Unit Punishment Book. We also reviewed DUI and alcohol incident statistics for 2013 and 2014.

f. Reviewed Navy Medicine East (NAVMEDEAST) Inspector General (IG) records pertaining to NMCP complaints within the past two years.

g. Toured the Medical Center, including several medical wards, both day and evening, and the barracks at Portsmouth where Sailors live.

h. Reviewed General Military Training (GMT), Personnel Qualification Standards (PQS), and Enlisted Sailor programs such as Command Indoctrination and Professional Development of enlisted personnel.

i. Received several briefings from command leadership including the Command brief, SAPR, Sexual Assault Forensic Examination (SAFE), Inpatient Staffing, NMCP Limited Duty Program, NMCP Health of the Force, and Patient Safety & Quality of Care.

j. Reviewed the management and administration of Limited Duty (LIMDU) personnel at NMCP, command manpower and manning levels, and the local Personnel Support Detachment (PSD) located on the NMCP campus.

OBSERVATIONS AND FINDINGS

1. Overall Assessment:

a. NMCP is a large, complex organization with a workforce that is very committed to its mission of providing world-class health care. The command has a total staff of 6,736 (officers, enlisted, General Schedule (GS) employees and contractors), an annual operating budget of $499M, 18 Directorates, 187 Departments, and 9 Branch Health Clinics ranging from Yorktown, Virginia to southern Chesapeake, Virginia.

b. The Medical Center and clinics work at a demanding pace. FY 2013 clinical statistics, which in many cases lead the Navy, document:

- 3,322 newborn deliveries (averaging 9 per day)
- Over 1.5 million outpatient visits
- 168,204 dental visits
- 14,680 admissions
- 13,429 surgeries
- Over 1.8 million outpatient prescriptions filled
- Over 3.6 laboratory tests
- 239,295 radiology procedures

c. The current Commander, NMCP took command 8 April 2014. He has fresh ideas and new goals for the command. The Deputy Commander will transfer in early June 2014. A planned change to the leadership organization will execute BUMED's strategy of placing an O-6 in command of the Medical Center in October 2014 and thereby allowing the assigned Rear Admiral to focus on his many other responsibilities including: Commander, Navy Medicine East; Director, Multi-Service Market; and Director, Medical Service Corps. Placing an O-6 in command of the Medical Center who is not dual-hatted with other significant responsibilities will allow greater leadership oversight of, and involvement in, the daily operation of NMCP.

d. Overall command climate at NMCP is not homogeneous, but varies depending on work center and placement within the organizational hierarchy. Mid-level leaders across the command and personnel assigned to the Surgical Services Directorate expressed the highest degree of dissatisfaction in focus group discussions. There is a perception by a number of Medical Center staff that some senior leaders are excessively direct, overbearing, and unwilling to listen to recommendations from subordinate and junior personnel. This creates an atmosphere that communications up the chain of command are not welcomed. We also heard in focus groups and other discussions that there is a fear of speaking up.

e. A high profile, alleged sexual assault case in November 2012 was followed several months later by the decision to take four sailors and an officer (separately) to open mast (non-judicial punishment proceedings) for alcohol related offenses. In the view of many personnel on the staff the actions taken at these masts were not equitable, and as a result perpetuated an atmosphere of two standards of conduct. This also added to a perception in the minds of some enlisted personnel that they were "expendable".

(1) In retrospect the command views the decision to conduct open mast as a mistake, but it will take time for this event to evolve from the corporate memory.

(2) Additionally, there is much speculation about the alleged sexual assault - this is hard to overcome as invariably many personnel have chosen sides. This event clearly caused significant repercussions within the command, especially among Directorate Heads. The command did conduct a series of small group seminars/discussions after this event covering fraternization, use of alcohol, intervention, etc.

f. Sexual Assault Prevention and Response (SAPR) program. The command is committed to the SAPR program, but there are several important areas of non-compliance that can be quickly fixed. SAPR roles and responsibilities within NMCP are not well defined, and sexual assault reporting, from first notification by the victim to notification of the Commander, involves far too many personnel, does not appropriately protect victim's privacy, and is not in accordance with governing instructions. Victim care and the Sexual Assault Forensic Examination (SAFE) program at NMCP are very impressive.

g. The command Physical Readiness Program is compliant with OPNAVINST 6110.1J. The program had been poorly run up through June 2013, but is now strong. A self-assessment of the program in July 2013 identified program shortfalls. NMCP implemented a series of personnel and process changes to bring the program back into compliance. Of note, Medical Officers who have outstanding service obligations but do not pass the PFA are not consistently processed out of the Navy by Navy Personnel Command (NAVPERSCOM PERS 8) when they exceed three PFA failures within a four year period. By BUMED and NAVPERS policy, some Medical Officers are retained either because of their outstanding service obligation or medical specialty. There are documented instances at NMCP where Medical Officers have been processed for administrative separation for PFA failures, but are ultimately retained by NAVPERS. This creates the perception that some Medical Officers at the command are not being held to the same standards as other members of the command.

h. Fraternization and Culture of Alcohol Abuse. We found no direct evidence of fraternization or a culture of alcohol abuse other than those few cases investigated by the command. Our observation is that the command is responsive to investigate and follow-up on reports of fraternization or misconduct. However, the command must continue to train and mentor their team to stay to the left of future problems. NMCP is susceptible to fraternization issues due to the close proximity in which many of their personnel operate, and have a potentially "at risk" population of officer interns and residents who are working hard and are new to the team. NMCP needs to have a proactive, rich, ongoing dialogue with these personnel about conduct (including off duty), alcohol, and fraternization. We saw evidence of some past dialogue along these lines.

i. Workload is increasing as the Medical Center attempts to “recapture” a portion of care that is currently referred to the Tricare network. This presents some significant challenges and creates tension between NMCP capacity, quality of life and perceptions of quality care. There are some barriers to reaching recapture goals, such as actual capacity limits and inefficiencies, including the time required to document care and treatment in the current medical record system.

Command leaders understand the current workload but will have to carefully monitor the demands on the staff as recapture efforts expand. Some Departments may not be able to recapture due to the nature of their work, limiting factors that they cannot control, and the fact that they are already at a very high level of productivity.

j. Communications at this large command are a challenge, but must improve. Leaders must proactively push information downward and must be willing to listen to feedback. More so than we usually see during other NAVINSGEN assessments, there is a sense by a number of personnel at NMCP that feedback up the chain of command is not always embraced, respected or acted upon.

k. All of the Medical Center's senior leadership (Directors, Command Master Chief, Deputy Commander, and Commander) occupies administrative spaces in Building One, separate from the rest of the Medical Center which operates out of other buildings on the campus. These leaders make their rounds in the Medical Center, and most of these providers attend to patients on a regular basis, however, the physical dislocation of these leaders is a potential barrier to effective communications and interactions. Additionally, the Commander is multi-hatted as Navy Medicine East; Director, Multi Service Market; and Director, Medical Service Corps, which collectively requires significant time away from the Medical Center.

l. The Medical Center has an effective means of managing a large population of LIMDU personnel, but should document their process in an instruction. This program will require regular and consistent monitoring by leadership to ensure effectiveness and avoid risk.

2. Command Climate. We assessed command climate through many vehicles including a pre-arrival online survey, focus group discussions, individual interviews, and interactions with people in their work environments, as well as review of Defense Equal Opportunity Management Institute (DEOMI) Organizational Climate Survey (DEOCS) results from 2011 and 2012. Overall command climate ranges from fair to very good: there are Departments with very healthy climates and others that face challenges and have room for improvement.

a. We found, both through survey data and direct observation, that the NMCP staff is very dedicated to their jobs and patient care, and they are clearly passionate about what they do.

b. Contractors and Department of Navy civilians comprise 50% of the Medical Center staff. A number of civilian personnel felt that they felt they were less valued in the command than military personnel.

c. Command climate is not homogeneous across NMCP: an individual's perception is a function of their work center and relative seniority. Personnel assigned to the Surgical Services Directorate and mid-level leaders expressed the highest degree of dissatisfaction in focus group discussions. A number of mid-level leaders, both military and civilian, were frustrated that their feedback up the chain of command is not requested or considered when given.

d. We found no indications of an abusive environment or situation where people are ill-treated, verbally abused or otherwise treated in a disrespectful manner. We do note that some

senior leaders are perceived by the Medical Center staff as overly direct, overbearing, and unwilling to listen to recommendations from junior personnel. From the survey data, focus group discussions, and interviews, we gained a sense that there is fear of speaking up (not uniformly across the staff, but existent among a number of individuals).

e. Thirty-eight percent of survey respondents indicated that their command climate rating was negatively impacted by unit morale: this is a large portion of the command that has a negative view of unit morale. Focus group comments indicated that a handful of events and initiatives that occurred in the past 18 months have had a particularly negative impact. These include:

(1) Two open Article 15 proceedings for DUI cases over a year ago, one involving three enlisted personnel and the other involving an officer, had a disruptive effect across the command creating perceptions of unequal standards when the case against the officer was dismissed and the enlisted personnel were punished. Regardless of the facts associated in each of these cases, personnel at the command have the perception that the officer escaped punishment while the enlisted personnel were severely disciplined. This event had a profound impact on command personnel and was a frequent discussion topic with NMCP personnel.

(2) An alleged sexual assault case in 2012 involving command personnel that was covered by local media.

(3) Tension between an increasing workload from recapture initiatives and perceptions of the impact on quality of patient care, safety, and staff quality of life.

f. Twenty-eight percent of respondents indicated that their command climate rating was negatively impacted by trust in leadership and 27% indicated that it was negatively impacted by confidence in leadership. NAVINSGEN assesses that the events and initiatives identified above most likely contributed to these ratings.

3. Health of the Force (i.e. quality of work, quality of life, personal development, etc.). Broad issues affecting command personnel are tracked by leaders and actively briefed at the Command Executive Board (CEB) which serves as a Board of Directors. For example, DEOMI DEOCS results are briefed by each Director to the Commander and followed up with a plan to address identified issues. General DEOCS results are also briefed to the CEB as well as retention, Drug and Alcohol Programs (DAPA), Command Managed Equal Opportunity (CMEO) and Equal Employment Opportunity (EEO) program indicators and trends.

a. NMCP has a strong commitment to developing its people. We saw evidence of a large number of programs and initiatives in place to mentor, develop and support their team, such as:

(1) A Leadership Expectations Workshop pilot developed by the command to address topics identified in the DEOCS.

(2) Mentorship programs for officers and enlisted personnel.

(3) Real Talk No Rank - discussion groups initiated by senior enlisted leaders that focus on hard hitting topics of significant interest to Sailors and affecting good decision making.

(4) An active set of associations including Chief Petty Officer, First Class Petty Officer, Second Class Petty Officer, Junior Enlisted Associations, Coalition of Sailors Against Destructive Decisions. We also observed an active and very positive effort by Hospital Corpsmen to raise money for the upcoming Corpsman Ball.

b. DUI and alcohol related incidents (ARIs). In FY 2013, NMCP had 7 DUIs and 26 ARIs. To date, in FY 2014, there have been 3 DUIs and 8 ARIs.

c. We recommend that NMCP consider some form of consolidated report or roll-up of "health of the force" metric/data to assist leaders in their decisions and awareness of command wide issues.

4. Sexual Assault Prevention and Response (SAPR) program.

a. Medical Center leadership is committed to ensuring an environment free of sexual assault (SA). Our pre-arrival survey data shows that over 88% of personnel at NMCP do not question the integrity of the SAPR program. However, Victim Advocate (VA) focus group participants identified potential barriers to SA reporting at the command stemming from a perceived lack of confidentiality in the reporting process as a major concern. We were not able to quantify the scope of this perception at the command; however, we identified two possible causes for this perception:

(1) The command has too many people involved in the SA reporting chain between the victim and the Commander. There is also no consistency in the manner that these reports flow to the Commander. For example, Victim Advocates report sexual assaults to Senior Enlisted Leaders in their chain of command. In accordance with OPNAVINST 1752.1B, the report chain should go from the victim, to the VA, to the Sexual Assault Response Coordinator (SARC) and to the Commander.

(2) In the Medical Community, anyone with access to medical records could view a victim's record; medical personnel in our focus groups expressed concern about privacy among their peers. In accordance with Medical Center procedures, providers are required to mark medical records "sensitive" and code them as an "assault" in the event of a SA. An electronic audit trail is maintained for records marked in this manner to deter personnel without a need to know from viewing them. This special marking of records, and the associated audit trail, are not well understood by personnel across the command, and need to be explained to help rectify perceptions of lack of confidentiality.

b. Overall the program is not compliant with OPNAVINST 1752.1B. Sexual assault victim reports are relayed through multiple levels in the chain of command, compromising confidentiality. A number of personnel with key roles in the SAPR program have not been formally trained or appointed. The SAPR POC manages all aspects of the SAPR program for NMCP in addition to robust primary responsibilities as a Clinical Nurse Specialist and Chair of

the Medication Management Team. The command SAPR instruction is inaccurate, creating confusion with reporting procedures for victims and staff to include watch standers.

c. Strengths identified during our visit:

(1) NMCP has a well-established and exceptionally well run Sexual Assault Forensic Examination (SAFE) program overseen by the Sexual Assault Forensic Nurse Examiner (SANE). The Emergency Department has standard procedures and the staff is knowledgeable, well trained and equipped to provide immediate evidence collection and excellent care for victims who desire to file restricted or unrestricted reports or seek medical treatment only.

(2) Voice and message reporting and tracking by the Data Collection Coordinator (DCC) and Officer of the Day (required per OPNAVINST 3100.6J) is robust, well organized, and detailed.

d. The NMCP SAPR program structure and processes do not fully comply with governing DoD, SECNAV, and OPNAV SAPR instructions. Specifically:

Deficiency #1. Key SAPR program personnel (SAPR Liaison, SAPR Point of Contact (POC), SAPR Victim Advocates (VA), and SAPR Data Collection Coordinator (DCC)) are not all formally designated in writing by the Commander, as required by OPNAVINST 1752.1B.

Deficiency #2. Key SAPR program roles and responsibilities are in some cases not well defined, causing confusion within the command. For example, two recently appointed Senior Chief Petty Officers serve as "SAPR Liaisons" with stated roles of "only processing expedited transfers", counter to the SAPR Liaison roles and responsibilities defined in OPNAVINST 1752.1B.

Deficiency #3. Not all personnel with SAPR roles have received required training from the SARC, per OPNAVINST 1752.1B. Specifically: 1 of 3 SAPR Liaisons and 2 of 5 SAPR POCs are not trained. NMCP could not verify that training had been completed for 8 of 54 VAs.

Deficiency #4. The SA reporting chain from victim to Commander includes numerous additional personnel within the command (including the SAPR Liaison and Senior Enlisted Leaders, and other personnel within the chain of command), does not preserve victim confidentiality, and is not in accordance with OPNAVINST 1752.1B.

Deficiency #5. NMCP does not conduct formal watch stander training to ensure that proper response protocols are in place for watch standers to respond to sexual assault (SA) victims/incidents per SECNAVINST 1752.4B. Watch standers only received the SAPR General Military Training (GMT) and command indoctrination training.

Deficiency #6. The SAPR Liaison attends the Sexual Assault Case Management Group (SACMG) on behalf of the Commander, counter to the requirements of SECNAVINST 1752.4B. Either the Commander must attend and provide an update to a SA victim within 72 hours after the SACMG, or the Deputy Commander is designated to do so. The Deputy Commander did attend one SACMG meeting in the past for the Commander, but had not been formally authorized in writing to do so. When the Commander delegates the authority to attend to the Deputy Commander, it must be documented in writing and widely publicized within the command. References: DoDI 6495.02, SECNAVINST 1752.4B and OPNAVINST 1752.1B.

Deficiency #7. SAPR information is not sufficiently promulgated across the command. Names and contact information of SARCs, SAPR Victim Advocates (VAs) and other first responders are not widely publicized at NMCP in accordance with DoDI 6495.02, SECNAVINST 1752.4B and OPNAVINST 1752.1B. There was no link to the Safe Help line on the command web page in accordance with SECNAVINST 1752.4B.

Deficiency #8. Expedited transfer packages are not currently being forwarded to PERS 833 for retention per MILPERSMAN 1300-1200.

Deficiency #9. The NMCP Command SAPR instruction, NAVMEDCENPTSVAINST 5830.5, dated 13 Feb 2013, is incorrect and does not reflect the requirements of the program as documented in DoD, SECNAV and OPNAV SAPR instructions. For example, the reporting chain from victim to Commander and the description of SAPR key personnel responsibilities are incorrect.

Recommendation #1. That the SAPR POC position be held by an individual with fewer competing requirements to ensure full programmatic compliance with directives. For this large of a command, it may be appropriate to assign this as a primary duty.

Recommendation #2. That the Commander attend SACMGs (to include SACMG on installations where Branch Health Clinics are located) or designate the Deputy Commander, in writing, authority to act as the Commander regarding SA victim response; formally communicate this designation to staff.

Recommendation #3. That the Command review the need for separate, command-level SAPR instruction. It may be more appropriate and effective to promulgate notices that specify procedures and issues that are unique to NMCP.

Recommendation #4. That the Command educate staff on respecting confidentiality with respect to sexual assault medical record documentation.

Recommendation #5. That the Commander meet with SARCs from all of the geographic areas that have NMCP clinics, not just the SARC for NMCP main facilities in Portsmouth.

5. Command Physical Readiness Program (PRP).

a. NMCP's PRP is effective and in compliance with OPNAVINST 6110.1J.

b. NAVINSGEN reviewed the Command Physical Readiness program by reviewing its Physical Readiness Information Management System (PRIMS) database, hard copy back-up records for personnel assigned, legal documents associated with administrative actions, either Enlisted Page 13s or Officer Letters of Correction (LOC) taken against personnel not complying with the program, observations of an actual Physical Fitness Assessment (PFA), including Body Composition Assessment (BCA) weigh-in and/or taping of personnel and the administering of actual Physical Readiness Test (PRT) events. No Fitness Enhancement Program (FEP) event was observed due to its suspension during the current PRT cycle; however, records were readily available for review to indicate an on-going effort to assist members in complying with applicable physical standards. All members assigned to FEP, due to BCA or PRT failures for a PFA cycle, are appointed in writing and counselled on the program requirements. FEP is offered 3 times per day, 0600/1100/1600, 5 days per week with participants receiving a weekly BCA and a monthly mock PFA.

c. The program was out of compliance a year ago, but in July 2013 the command self-assessed the program, identified shortfalls, improved its processes and procedures, replaced the Command Fitness Leader (CFL) and achieved compliance. The current CFL and all assigned Assistant Command Fitness Leaders (ACFLs) meet all requirements per OPNAVINST 6110.1J and the CFL has implemented a standardized program in all aspects, BCA and PRT, across the NMCP domain. All members are medically screened with a Periodic Health Assessment (PHA) and a Physical Activity Risk Factor Questionnaire (PARFQ) prior to a member being administered the BCA. All PHAs and PARFQs are signed by an Authorized Medical Department Representative (AMDR), duly appointed in writing, per OPNAVINST 6110.1J, Enclosure (1).

d. Personnel Support Detachment (PSD) is not drafting Page 13s for NMCP personnel who fail the PFA, as required. Navy Transaction Online Processing System (TOPS) access is required in order to generate these Page 13s. PSD has access to TOPS while NMCP Personnel Division (MILPERS) does not. As a result, PRT failures are not properly documented for Enlisted Personnel, other than in PRIMS. Without the required Page 13, repeated PRT failures cannot result in administrative separation. NAVINSGEN visited PSD and educated the Officer in Charge (OIC) regarding the issue of Page 13s not being drafted and signed. He indicated that this was the first time this had been brought to his attention and that he would correct the situation. We also engaged with the Physical Readiness Control Officer at Navy Medicine East (NMCP's Immediate Superior in Command), who will follow up with PSD to ensure that corrective action is taken.

e. Per OPNAVINST 6110.1J, all community management and policy decisions affecting medical officers must be referred to BUMED, Total Force Directorate (M1) for review and approval. Medical Officers who have outstanding service obligations but do not pass the PFA are not consistently processed out of the Navy by Navy Personnel Command (NAVPERSCOM PERS 8) when they exceed three PFA failures within a four year period. By BUMED and NAVPERS policy, some Medical Officers are retained either because of their outstanding service obligation or medical specialty. There are documented instances at NMCP where

Medical Officers have been processed for administrative separation for PFA failures, but are ultimately retained by NAVPERS. This creates the perception that some Medical Officers at the command are not being held to the same standards that other members of the command are.

6. Limited Duty (LIMDU) Program. NAVINSGEN reviewed the management of LIMDU personnel at NMCP as the topic was raised during focus group discussions.

a. The management of LIMDU personnel at NMCP is being conducted in accordance with applicable policy and guidance including MILPERSMAN 1306-1200, Limited Duty (LIMDU), BUPERSINST/BUMEDINST 1306.72H, Policy and Procedures Concerning Medical Transition Personnel and Medical Transition Company, and BUPERSINST 1306.77C, Manual for the Administration of Transient Personnel Units.

b. NMCP's management of LIMDU personnel was assessed by conducting document review as well as interviews with the Mobilization Coordinator and his staff, the suitability screening staff, and four personnel assigned to NCMP on limited duty. NMCP has a good process to manage, track and assign LIMDU personnel to divisions at NMCP; however, the process has not been formalized in a command instruction. Additionally, command leadership is not routinely briefed on the status of LIMDU personnel at the command. Our review of LIMDU management at NMCP identified several challenges associated with LIMDU personnel care and management, addressed below.

c. A growing number of LIMDU personnel at NMCP have mental health issues as primary diagnoses or as co-occurring conditions to other diagnoses. Changes in Department of Defense policy governing care of mental health patients have shifted these servicemembers away from a relatively quick path to administrative separation to placement in a LIMDU, Physical Evaluation Board (PEB) process. This increased load of patients with mental health issues creates a management challenge as some of these patients may have behavioral issues. NMCP reported that follow-up appointments for these mental health patients are limited, leading to delays in improvement and longer time in a LIMDU status. NMCP is fully aware of this issue and is working to redesign care for this group.

d. The total number of LIMDU personnel assigned to NMCP, and percentage of these personnel with mental health issues, from 2012 to date, has grown; specifically:

(1) 2012: 316 total, 65% with mental health issue

(2) 2013: 547 total, 76% with mental health issues

(3) 2014 to date: 488 total, 88% with mental health issues

e. NMCP reports that, on average, LIMDU personnel spend 3-4 months in a LIMDU status, for a variety of reasons, before they are transferred to NMCP from Transient Personnel Units (TPUs). This results in treatment delays and increases the likelihood that an individual will need to be extended in a LIMDU status. Factors causing transfer delays from TPU include:

(1) Delays in TPU receiving orders from the Bureau of Naval Personnel (BUPERS) to transfer personnel to NMCP.

(2) TPU will not transfer personnel if they are on hold for legal reasons or on restriction, which is not uncommon due to associated behavioral issues.

(3) Personnel reporting to TPU from overseas locations without an Abbreviated Medical Board Report (NAVMED 6100/5).

(4) Personnel transferred by BUPERS from overseas locations in ACC 105 status without initiation of a Medical Board.

f. NAVINSGEN will address the transfer delays described above with Commander, Navy Personnel Command, separately.

Recommendation #6. That NMCP develop a command instruction to formalize the processes in place to manage LIMDU personnel.

Recommendation #7. That command leaders at the CEB be routinely briefed on the status of LIMDU personnel at the command.

7. Command Legal Records. An inspection of the Staff Judge Advocate's (SJA) office was conducted and consisted of interviews of key personnel, review of officer and enlisted Administrative Separations for 2013 and 2014 to date (121 cases), and an examination of the Unit Punishment Book.

a. The NMCP SJA Office is currently staffed with 2 uniformed attorneys, a Navy Medicine East/NMCP civilian attorney, 7 GS civilians, one active duty Legalman and several limited duty and other personnel. The staff is integrated to provide legal advice and services to both NAVMEDEAST and NMCP. Current staffing is appropriate but the manning construct will face challenges when the NMCP Commander is no longer dual-hatted as NAVMEDEAST. The SJA is aware of the potential issues and will develop a way ahead.

b. The SJA Office is fully engaged in the mission to support good order and discipline. The office tracks military justice (i.e., both court-martial and Non-Judicial Punishment (NJP)) cases, officer and enlisted administrative separations, civilian court cases, military protective orders, and ongoing investigations. This "Military Justice Status Report" tracker follows cases from "cradle to grave" and is updated on a weekly basis. This process is effective in ensuring that the SJA Office can track a myriad of legal issues that are encountered by NMCP.

c. Interviews with key personnel revealed no double standard in the handling of cases involving officers and enlisted personnel. It appears clear that there is a robust effort to fully investigate cases and no artificial barriers have been erected by leadership to protect officers or senior enlisted personnel. As required, SA cases are referred to NCIS for investigation. Once investigations are complete, the SJA refers the cases to the Region Legal Service Office Mid-

Atlantic for case screening for recommendation as to disposition. No discrepancies were noted in the handling of sexual assault cases.

d. Physical Readiness Program (PRP). NAVINSGEN noted no deficiencies in the processing of PFA failures for officers or enlisted personnel by the SJA office. The processing of those cases appears to be fair. We did note several issues with weak documentation of failures, including but not exclusively officer cases. For the Fall 2013 Physical Fitness Assessment (PFA) cycle there were 42 three-time failure cases forwarded to the SJA office for processing. Of the 42 cases, 16 cases lacked the requisite documentation (either Page 13s or Letters of Instruction). We note that the SJA office was working with NMCP PFA personnel to resolve these deficiencies, but some of the issues were with members' previous commands. It appears that differences in how PFA failures are handled (e.g., PFA readiness waivers for Medical Officers who fail 3 PRTs in a four year period but are retained because they have an outstanding service obligation or unique medical specialty) can be attributed to Navy Policies rather than a failure to properly execute the PRP at NMCP.

e. Open Mast Cases. NAVINSGEN reviewed the three enlisted cases and one officer case that were the subject of open Mast proceedings on 11 Mar 2013 and 13 Mar 2013 respectively. We reviewed all of the underlying documentary evidence as well as the subsequent correspondence related to NJP appeals for the enlisted personnel. While conducting open mast on the three enlisted personnel appears to have been unnecessarily rushed and, in retrospect, may not have afforded the command an opportunity to fully assess the impact, it was not prohibited and was within the prerogative of the Deputy Commander who conducted the proceedings. With respect to the officer mast conducted by the Commander, dismissal of the charges against the officer, while perhaps damaging to morale, was within the Commander's discretion. NAVINSGEN interviews with the SJA discussed the merits and risks of open Mast proceedings.

8. Other Areas/Programs. The following areas and programs were reviewed during the visit; however, no significant issues were identified:

a. Sailor Programs. The Sponsorship, Command Indoctrination Programs, Sailor Career Development Programs and GMT were found to be compliant.

b. Manpower and Manning. The command manning: Active Duty Officers: 99%; Active Duty Enlisted: 136%; DON civilian employees: 88% (101% including personnel in recruitment); and contractors: 111%. We did not assess productivity; however, it is clear that the Medical Center has the tools, expertise, and data to keep leadership and BUMED accurately informed of productivity and capacity.

PART 3

REPORT ON SURVEY AND FOCUS GROUPS

APPENDIX A

SUMMARY OF SURVEY DATA ANALYSIS

1. Method. In support of the Naval Medical Center Portsmouth (NMCP) Command Assessment held 21-25 April 2014, the Naval Inspector General (NAVINSGEN) conducted an anonymous on-line survey of active duty military and Department of the Navy (DON) civilian personnel from 14-18 April 2014. The survey produced 2,122 respondents (1,342 military, 780 civilian). Based on the reported population the sample was representative and exceeded target statistical parameters.

a. Survey questions are listed in Appendix C. Data is provided for forced-choice response questions.

b. Respondents selecting "strongly agree" to whether fraternization or sexual harassment occurs at NMCP were prompted to describe the nature of the fraternization or sexual harassment.

c. Respondents selecting "strongly agree" to perceived lack of integrity in the physical readiness or sexual assault prevention programs were prompted to describe the absence of integrity in these programs.

d. Respondents selecting "always" to the frequency of excessive alcohol use at NMCP functions or morale and welfare events were prompted to describe the nature of the alcohol use.

2. Command Climate.

a. Command climate (CC) was assessed using a scale from 1 to 10, where 1 is worst and 10 is best. The overall NMCP CC average was 5.73 (Fig. A-1).

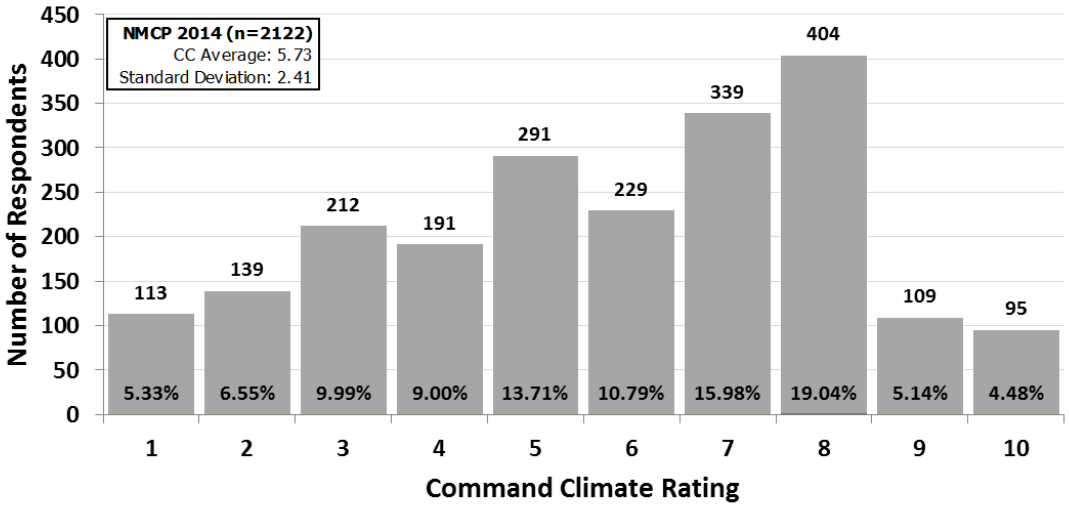

Fig. A-1. Distribution of command climate ratings from the pre-event survey. The x-axis lists the rating scale and the y-axis represents the number of survey respondents. Response percentages for each rating are shown at the base of each bar. Counts for each rating are shown above each bar.

b. The perceived impact of 13 factors on CC rating is shown in Table A-1. Response percentages are summarized as either having a negative or other (positive or neutral) impact on command climate. Factors of potential concern were identified by distributional analyses. Percentages in Table A-1 that are significantly higher or lower than 20% are shown in bold text. Subgroup comparisons are not summarized in Table A-1. However, officers indicated leadership at the executive level as a negative impact on CC rating more often than enlisted (26% vs. 10.4%). Civilians indicated professionalism in the workplace as a negative impact on CC rating more often than active duty military (19.5% vs. 11.4%). Females indicated professionalism in the workplace as a negative impact on CC rating more often than males (17.8% vs. 11.5%).

Table A-1. Impact of Factors on Command Climate Rating

Factor	Negative	Other
Mission	**4.76%**	95.24%
Trust in Leadership	**28.13%**	71.87%
Confidence in Leadership	**26.96%**	73.04%
Leadership Competence	19.37%	80.63%
Leadership (Executive)	**16.92%**	83.08%
Leadership (Department/Division)	18.19%	81.81%
Leadership (Immediate Supervisor)	17.34%	82.66%
Unit Cohesion	20.26%	79.74%
Unit Morale	**31.95%**	68.05%
Job Satisfaction	17.44%	82.56%
Communication Within Department/Division	21.96%	78.04%
Communication Between Departments/Divisions	**27.29%**	72.71%
Professionalism in the Workplace	**14.37%**	85.63%

Notes: Perceived impact of factors on command climate rating. Percentages of negative versus aggregate positive and neutral (Other) responses. Negative values in bold are either significantly greater or less than 20%.

c. Table A-2 summarizes survey questions that assessed the perceived occurrence of fraternization at NMCP, and whether respondents questioned the integrity of the sexual assault and physical readiness programs at NMCP. The range of military ranks and civilian grades at NMCP resembles NAVINSGEN area visits (AV). The perceived occurrence of fraternization (23%) as indicated by aggregate strongly agree and agree response percentages was comparable to the 2009-2014 NAVINSGEN AV average (22%). Baseline NAVINSGEN data for the sexual assault and physical readiness questions do not exist for comparison. Twelve percent of respondents questioned the integrity of the Sexual Assault and Physical Readiness programs. Military (18.7%) respondents questioned the integrity of physical readiness more than civilians (11.3%).

Table A-2. Perceived Occurrence of Fraternization and Integrity of the Sexual Assault and Physical Readiness Programs

Question Topic	SA+A	Other
Fraternization	23%	77%
Sexual Assault	12%	88%
Physical Readiness	16%	84%

Notes: Aggregate strongly agree and agree (SA+A) response percentages versus other responses. Lower response percentages are "better." Perceived fraternization comparable to NAVINSGEN 5-year Area Visit percentage (22%). No baseline data for Sexual Assault or Physical Readiness.

3. Verbatim Responses.

a. Fraternization. Survey respondents who strongly agreed that fraternization occurs at NMCP were prompted to describe their perceptions in greater detail. Many comments were either vague or were written as hearsay. There were some general statements recognizing that fraternization occurs at NMCP, however none of them provided sufficient information for follow-up.

b. Sexual Assault Prevention & Response. Survey respondents who strongly questioned the integrity of the Sexual Assault Prevention & Response Program at NMCP were prompted to describe their perceptions in greater detail. Strong opinions were offered about a high-profile sexual assault case that was investigated in 2013. Some respondents expressed concern for false accusations of sexual assault and others offered various critiques of the Navy's SAPR program. In some cases it was not clear that respondents had a clear understanding of the differences between sexual harassment and sexual assault.

c. Physical Readiness Program. Survey respondents who strongly questioned the integrity of the Physical Readiness Program at NMCP were prompted to describe their perceptions in greater detail. Some respondents expressed concern for accountability, some felt that officers are held to different standard than enlisted, while others offered various critiques of the Navy's program.

d. All survey respondents received a closing open-ended free-text question to capture additional comments associated with command climate. No clear pattern of responses emerged from these comments, which encompassed the range of topics (e.g., manning/manpower, workload, work schedule, pay, facilities) often raised in surveys and focus groups supporting NAVINSGEN command inspections and area visits.

e. Some respondents reported inability to take leave or work schedules that were in flux to the extent that it was difficult to plan ahead for vacations.

APPENDIX B

SUMMARY OF FOCUS GROUPS

1. Method. Randomly active duty military and DON civilian employees throughout NMCP received invitations to participate in focus groups. On 21-22 April 2014 the NAVINSGEN conducted a total of 19 focus groups at NMCP, 12 with various groupings of active duty military ranks, and 7 with various groupings of civilian grades. We also visited Boone Branch Health Clinic (chosen as a convenience sample of an outlying clinic) on 23 April 2014 to conduct 23 randomly selected individual interviews (8 officers, 8 enlisted, 7 civilians). There were a total of 129 focus group and interview participants; 73 military, 56 civilians. Each focus group was scheduled for one hour and consisted of one facilitator, two note takers, and perhaps observers from the assessment team. The facilitator followed a protocol script: (a) focus group personnel introductions, (b) brief introduction to the NAVINSGEN mission, (c) privacy, Whistleblower protection, and basic ground rules, (d) participant-derived list of topics perceived to impact command climate, and (f) subsequent discussion on participant-derived topics. Facilitators asked clarifying questions and when appropriate, prompted discussion on the primary topics of interest. Note takers transcribed focus group proceedings, subsequently reviewed to elucidate themes and, as appropriate, target further inquiry during our on-site assessment. Interviews followed the focus-group template but normally lasted 10-15 minutes.

2. Command Climate Topics

a. Fraternization

(1) When prompted to discuss fraternization, some active duty participants felt that fraternization occurs at NMCP; however participants also declared that fraternization was not tolerated.

(2) When prompted to discuss fraternization, some enlisted participants indicated an awareness of posted information on fraternization policy.

(3) Civilian focus group participants framed this topic in terms of “favoritism.”

(4) There were no comments to suspect that leadership ignores formal claims.

b. Sexual Assault Prevention & Response

(1) When prompted to discuss sexual assault, enlisted participants generally viewed the process as fair; however, some individuals thought that forcing the victim into the Navy program might result in “re-victimization” and expressed a desire for greater support for reporting or treatment options external to the chain of command.

(2) It was unclear whether focus group participants understand differences between sexual assault and sexual harassment.

c. Physical Readiness

When prompted to discuss physical readiness, enlisted participants generally thought that the program is well-run. In terms of administrative actions however, enlisted participants generally perceived double-standards in application of rules and requirements between officer and enlisted personnel.

d. Alcohol Use

Excepting the open masts regarding DUI and a recent sexual assault case, alcohol use was not mentioned during focus groups. When prompted it was not perceived as a command climate issue.

e. Participant-Derived Themes

(1) Open masts for DUI incidences that occurred in 2013 continue to have unintended negative consequences on unit morale and trust, especially for enlisted personnel.

(2) NMCP providers generally feel tension between productivity and quality of patient care. The tension is more prominent with personnel who are closer to direct patient care. Discussions often invoked perceptions of suboptimal manning/manpower, poor command communication between executive level personnel and providers, and respect for professional opinions.

(3) Patient Safety Reports (PSR) were perceived only as a mechanism for punishment rather than as a means to explore process improvement and avoidance of safety mishaps.

(4) The sequestration and furlough had unintended negative consequences on civilian morale and their sense of value to the organization.

APPENDIX C

SURVEY RESPONSE FREQUENCY REPORT

Respondent Demographics	#	%
Officer Male:	304	14%
Officer Female:	203	10%
Enlisted Male:	533	25%
Enlisted Female:	302	14%
Civilian Male:	238	11%
Civilian Female:	542	26%
Military:	1342	63%
Civilian:	780	37%
Male:	1075	51%
Female:	1047	49%

Command climate is a combination of many variables that define the general "health" of a command, such as: trust, confidence, and competence in leadership; cohesion, morale, mission and job importance, communication, professionalism, etc...

Rate your command climate on a 10-point scale where 1 is "worst" and 10 is "best" (select one rating).

	Command Climate Rating										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Count	113	139	212	191	291	229	339	404	109	95	**2,122**
%	5.33%	6.55%	9.99%	9.00%	13.71%	10.79%	15.98%	19.04%	5.14%	4.48%	

For each of the factors below, please indicate whether it has a positive, neutral (to include not applicable), or negative impact on your command climate rating.

	Positive	Neutral	Negative
Mission	1477	544	101
Trust in Leadership	826	699	597
Confidence in Leadership	835	715	572
Leadership Competence	909	802	411
Leadership (Executive)	931	832	359
Leadership (Department/Division)	1157	579	386
Leadership (Immediate Supervisor)	1256	498	368
Unit Cohesion	902	790	430
Unit Morale	723	721	678
Job Satisfaction	1070	682	370
Communication Within Department/Division	1036	620	466
Communication Between Departments/Divisions	659	884	579
Professionalism in the Workplace	1105	712	305

Fraternization is defined as a personal relationship between an Officer and Enlisted member or a Chief Petty Officer and a junior enlisted member that that has crossed the boundary of a senior-subordinate working relationship and doesn't respect differences in grade or rank. Such relationships are prejudicial to good order and discipline and violate long-standing traditions of the naval service.

Fraternization is occurring within the NMCP enterprise.

Strongly Disagree	Disagree	Neither...	Agree	Strongly Agree
195	350	1086	371	117
9.20%	16.52%	51.25%	17.51%	5.52%

I question the integrity (honesty/fairness) of the sexual assault prevention program within the NMCP enterprise.

Strongly Disagree	Disagree	Neither...	Agree	Strongly Agree
482	624	753	189	64
22.82%	29.55%	35.65%	8.95%	3.03%

I question the integrity (honesty/fairness) of the physical readiness program within the NMCP enterprise.

Strongly Disagree	Disagree	Neither...	Agree	Strongly Agree
387	563	833	265	74
18.24%	26.53%	39.26%	12.49%	3.49%

Excessive alcohol use occurs at official functions and/or morale and welfare events within the NMCP enterprise.

Never	Rarely	Sometime	Frequently	Always
8	13	5	0	1
29.63%	48.15%	18.52%	0.00%	3.70%

Sexual Harassment occurs within the NMCP enterprise.

Strongly Disagree	Disagree	Neither...	Agree	Strongly Agree
4	11	35	19	5
5.41%	14.86%	47.30%	25.68%	6.76%